Sec. 19a-495-571. Licensure of recovery care centers and standards for In-Hospital Recovery Care Centers.

(a) **Definitions.** As used in this section:

(1) "Administer" means to initiate the venipuncture and deliver an IV fluid, IV admixture, blood and blood components into the blood stream via a vein; monitor the patient; care for the venipuncture site; terminate the procedure; and record pertinent events and observations.

(2) "Care partner" means an individual whose intent is to help the patient in his or her recovery. A care partner may provide assistance with personal care and routine needs.

(3) "Commissioner" means the Commissioner of the Department of Public Health and Addiction Services, or his or her designee.

(4) "Community pharmacy" means a pharmacy licensed pursuant to Section 20-168 of the Connecticut General Statutes. An exception may be made for those cases in which a specific patient has a third party prescription drug plan that requires the patient to obtain medications from a specific pharmacy located outside the State of Connecticut, provided such pharmacy complies with the requirements of the State of Connecticut regulations and the policy of the facility regarding labeling and packaging.

(5) "Department" means the Connecticut Department of Public Health and Addiction Services.

(6) "IV admixture" means an IV fluid to which one or more additional drug products have been added.

(7) "IV fluid" means sterile solutions intended for intravenous infusion.

(8) "IV therapy" means the introduction of an IV fluid or IV admixture into the blood stream via a vein for the purpose of correcting water deficit and electrolyte imbalances, providing nutrition, and delivering antibiotics and other therapeutic agents approved by the facility's medical staff. "IV Therapy" also means the introduction of blood and blood components into the blood stream via a vein.

(9) "IV therapy nurse" means a registered nurse who is qualified by education and training and has demonstrated proficiency in the theoretical and clinical aspects of IV therapy to administer an IV fluid, IV admixture, blood and blood components.

(10) "IV therapy trainer" means a registered nurse who has been certified in IV Therapeutics by the National Intravenous Therapy Association and possesses current certification from that entity.

(11) "IV therapy program" means the overall plan by which the facility shall implement, monitor and safeguard the administration of IV therapy to patients.

(12) "Life support system" as defined in section 19a-570 (1) of the Connecticut General Statutes means any medical procedure or intervention which, when applied to an individual, would serve only to postpone the moment of death or maintain the individual in a state of permanent unconsciousness. In these circumstances, such procedures shall include, but are not necessarily limited to, mechanical or electronic devices including artificial means of providing nutrition or hydration.

(13) "Nurse's aides" means unlicensed workers employed and trained to assist licensed nursing personnel and entered on the nurse's aide registry maintained by the department.

(14) "Practitioner" means a physician, dentist or other person authorized to prescribe

drugs in the course of professional service in the State of Connecticut.

(15) "Qualified social work consultant" means a person who possesses at least a master's degree in social work from a college or university that was accredited by the Council on Social Work Education at the time of his or her graduation, and has at least two (2) years of post graduate social work experience in a health care setting.

(16) "Qualified social worker" means a person who possesses at least a bachelor's degree in social work from a college or university that was accredited by the Council on Social Work Education at the time of his or her graduation, and has at least one (1) year of post degree social work experience in a health care setting.

(17) "Recovery care center" or "center" means a center providing care and services to patients following an acute event as a result of illness, injury or exacerbated disease process and who are in need of a high degree of medical direction, but for whom acute-hospitalization is not required.

(A) An in-hospital recovery care center is a special unit of a licensed hospital and must be located attached to or on the grounds of a licensed hospital. Duplication of services is not required if the services are approximate to the point of service as determined by the department.

(B) A recovery care center is a freestanding licensed facility or otherwise specifically designated unit of a licensed facility that shall contain all of the elements for service and function contained in this section.

(18) "Reportable event" means an occurrence, situation or circumstance which is unusual or inconsistent with the policies and practices of the facility.

(19) "Supervision" means the direction, inspection, and on-site observation of the functions and activities of others in the performance of their duties and responsibilities.

(b) **Licensure procedure**

(1) Application for a separate license to operate a recovery care center may be made only by an existing facility which was operating independently as of July 1, 1994, and that has not been issued a license as a facility under any category in Connecticut General Statutes, Chapter 368v, Section 19a-490.

(2) If it is determined by the appropriate state agency that a certificate of need is required to operate a recovery care center, the certificate of need shall be a prerequisite to licensing or provision of service.

(3) Application for licensure

(A) No person shall operate a recovery care center without a license issued by the department in accordance with Connecticut General Statutes, Section 19a-491.

(B) Application for the grant or renewal of a license to operate a recovery care center shall be made to the department in writing, on forms provided by the department; shall be signed by the person seeking authority to operate the service; shall be notarized; and shall include, but not necessarily be limited to the following information:

(i) names and titles of administrative staff including the administrator, director of nursing services, supervisor or head nurse, medical director or specified physician;

(ii) patient capacity;

(iii) total number of employees, by category;

(iv) services provided;

(v) evidence of financial viability to include a projected two (2) year budget, including estimates of net income and expenditures, at the time of initial application, and balance sheet as of the end of the most recent fiscal year, at the time of license renewal;

(vi) certificate of malpractice and public liability insurance;

(vii) certificate of good standing, if applicable;

(viii) statement of ownership and operation, including, but not necessarily limited to the name and address of each owner and, if the center is a corporation, all ownership interests (direct or indirect) of ten percent (10%) or more and the name and address of each officer, director and member of the governing authority;

(ix) relevant statistical information requested by the department;

(x) agent for service; and

(xi) local fire marshal's annual certificate.

(C) The recovery care center shall notify the department of any changes in the information provided in accordance with subparagraph (B) of this subdivision.

(4) Issuance and renewal of license

(A) Upon determination by the department that the recovery care center is in compliance with the statutes and regulations pertaining to its licensure, the department shall issue a license or renewal of license to operate the center for a period not to exceed two (2) years.

(B) Application for license renewal shall be made in accordance with subparagraph (B) of subdivision (3) of this subsection and not less than thirty (30) days preceding the date of expiration of the center's current license.

(C) A license shall be issued in the name of the entity that has submitted application for the license.

(D) The license shall not be transferable to any other person, entity or service and shall be applicable only to the site for which it is issued.

(E) Each license shall list on its face, the name of the licensee, the "doing business as" name, the location, and the date of issuance and expiration.

(F) The license shall be posted in a conspicuous and centrally located place.

(G) The licensee shall immediately notify the department in writing of any change in administrative personnel of the recovery care center.

(H) Any change in the ownership of a recovery care center owned by an individual, partnership or association or the change in ownership or beneficial ownership of ten percent (10%) or more of the stock of a corporation that owns or operates such center, shall be subject to prior approval by the department. The licensee shall notify the department in writing of any such proposed change of ownership, at least ninety (90) days prior to the effective date of such proposed change.

(5) Suspension, revocation, denial, non-renewal or voluntary surrender of license

(A) A license may be suspended, revoked, denied or its renewal refused whenever in the judgment of the department the center:

(i) fails to comply with applicable regulations and/or laws prescribed by the commissioner;

(ii) furnishes or makes any false or misleading statements to the department in order to obtain or retain the license; or

(iii) fails to provide the mandatory care services on a continual basis.

(B) In the event of the suspension, revocation, denial or non-renewal of a license, the recovery care center shall be provided the opportunity for a hearing in accordance with the contested case provisions of Chapter 54 of the Connecticut General Statutes and Sections 19a-4-1 through 19a-4-31 of the regulations of Connecticut State Agencies, as applicable.

(C) Refusal to grant the department access to the patient's records, or staff of the center shall be grounds for suspension, revocation, denial or non-renewal of the license.

(D) Surrender of license. The center shall notify, in writing, each patient receiving services from the center, the next of kin or legal representative, and any third party payors concerned, at least fourteen (14) days prior to the voluntary surrender of a recovery care center license or surrender of license upon the department's order of revocation, refusal to renew, or suspension of license. Arrangements shall be made by the licensee for the continuation of care and services as required for patients following the surrender of the center's license.

(c) **General conditions for admission**

(1) Patients admitted to recovery care centers shall not require intensive care services, coronary care services, or critical care services. Recovery care services do not include surgical services, radiology services, pre-adolescent pediatric services or obstetrical services over twenty-four (24) weeks gestation.

(2) No patient whose condition is documented as terminal, in need of hospice care, below the Rancho Los Amigos Level VI of cognitive functioning or mentally incapable of recognizing that an emergency situation exists shall be admitted to the center.

(3) Admission to the center shall be restricted to patients who fall within the following categories and for whom it is reasonable to expect an uncomplicated recovery:

(A) emergency room procedures that do not require hospitalization;

(B) diagnostic or surgical procedures that do not routinely require hospitalization;

(C) medical, chemical or radiological treatments that are performed on an outpatient basis;

(D) medically stable hospitalized patients who require continued health care services to meet the hospital's discharge criteria (Intensity, Severity and Discharge (ISD-A) Severity of Illness, Intensity of Service Criteria); or

(E) patients requiring post surgical care who have had outpatient surgical procedures performed and who need or desire continued care.

(4) No patients who have had cardiac catheterizations may be admitted to the center with the exception of those patients who meet American College of Cardiology and American Heart Association Guidelines for cardiac catheterization Class I and are deemed stable by a cardiologist, which patients may not be admitted sooner than four (4) hours post cardiac catheterization procedure.

(5) No patient shall be admitted to an out-of-hospital recovery care center who requires support services from a hospital or a laboratory to ensure safety and stability of the patient's condition, including, but not necessarily limited to, blood gas monitoring.

(6) Lengths of stay shall be as follows:

(A) Patients admitted from any ambulatory surgical setting shall be limited to an anticipated three (3) day period of time. Patients who unexpectedly exceed a three (3) day period shall require a progress note written by the attending physician that shall justify the

unanticipated extended length of stay.

(B) Patients admitted from acute or community settings whose length of stay exceeds a three (3) day period require a progress note written by the attending physician every three (3) days that shall justify the extended length of stay for continuation of treatment.

(C) The length of stay shall not exceed twenty-one (21) days.

(d) **Governing body. Out-of-hospital recovery care centers**

(1) The center shall have a governing body which shall have the general responsibilities to:

(A) set policy;

(B) oversee the management and operation of the facility;

(C) ensure the financial viability of the facility; and

(D) ensure compliance with current standards of practice relative to any practice or procedure performed in the facility or by any professional staff or consultant utilized by the facility.

(2) Specific responsibilities of the governing body necessary to carry out its general duties shall include, but not necessarily be limited to, the following:

(A) adoption and documented annual review of written center and medical staff by-laws;

(B) development of an annual budget;

(C) annual review and update of the center's institutional plan, including anticipated needs, income and expenses;

(D) review of center compliance with established policy;

(E) appointment of an administrator who is qualified in accordance with subsections (e) (1) and (2) of this section;

(F) provision of a safe physical plant equipped and staffed to maintain the center and services;

(G) approval of an organizational chart which establishes clear lines of responsibility and authority in all matters relating to management and maintenance of the center;

(H) determination of the frequency of meetings of the governing body and documentation of such meetings through minutes;

(I) written confirmation of all appointments made or approved by the governing body; and

(J) adoption of a written policy concerning potential conflict of interest on the part of members of the governing body, the administration, medical and nursing staffs and other employees who might influence corporate decisions.

(e) **Administrator**

(1) The administrator shall possess a master's degree in a health related field or in administrative studies. If the administrator is a physician, he or she shall also possess an unrestricted license for the practice of medicine in the State of Connecticut.

(2) The administrator shall have two (2) years of administrative experience in a health care facility.

(3) The administrator shall be responsible for the following:

(A) enforcing any applicable local, state and federal laws, and regulations and center by-laws;

(B) appointing, with the approval of the governing body, of a medical director who is

qualified under subsection (i) of this section and a director of nursing services who is qualified under subsection (n) of this section;

(C) serving as a liaison between the governing body, medical and nursing staffs, and other professional and supervisory staff;

(D) appointing, in writing, and with the approval of the governing body, a responsible employee to act in his or her behalf in temporary absences;

(E) employing qualified personnel in sufficient numbers to assess and meet patient needs including the provision of orientation and training as necessary, with the advice of the medical director and director of nursing services;

(F) defining the duties and responsibilities of all personnel classifications;

(G) maintaining a patient roster and a daily census of all patients admitted and discharged by the facility which shall be submitted to the department the last day of each quarter unless otherwise requested and shall include but not necessarily be limited to the following information:

(i) admission date, discharge date and length of stay;

(ii) diagnosis;

(iii) type of admission;

(iv) reason for admission;

(v) surgical procedure, if applicable;

(vi) identification of any medical or surgical complication that developed during patient's stay;

(vii) discharge location;

(viii) any other information requested by the department; and

(H) developing a coordinated program for orientation to the center, in-service training and continuing education for all categories of staff in order to develop skills and increase knowledge so as to improve patient care, in cooperation with the medical director and director of nursing services.

(4) The administrator or the administrator's designee for an out-of-hospital recovery care center shall serve no less than twenty (20) hours per week on the premises of the center and shall be on twenty-four (24) hour call for a center of twenty-one (21) or less beds.

(5) The administrator or the administrator's designee for an out-of-hospital recovery care center shall serve full time on the premises of the center, and shall be on twenty-four (24) hour call, for a center of more than twenty-one (21) beds.

(6) The administrator or the administrator's designee for an in-hospital recovery care center shall serve no less than ten (10) hours per week on the premises of the center and shall provide for twenty-four (24) hour on-call coverage.

(f) **Personnel policies for a recovery care center**

(1) A recovery care center shall have written personnel policies that shall include but not necessarily be limited to:

(A) documentation that all employees have satisfactorily completed an orientation program appropriate to their job description;

(B) provision of in-service education at least quarterly, with content appropriate to the scope of services provided;

(C) policy and procedure for annual performance evaluations, which includes a process

for corrective action when an employee receives an unsatisfactory performance evaluation;

(D) job descriptions;

(E) physician documentation of biennial physical examinations; and

(F) annual tuberculin testing.

(2) For all employees of the recovery care center, the center shall maintain individual personnel records containing at least the following:

(A) an application that contains educational preparation and work experience;

(B) verification of current licensure or certification as appropriate;

(C) written annual performance evaluations;

(D) signed contract or letter of appointment specifying conditions of employment;

(E) record of health examinations; and

(F) documentation of orientation.

(g) **Patients' bill of rights.** A patients' bill of rights shall be implementedfor each patient admitted to the center. A notice shall be conspicuouslyposted on each nursing unit that states the following: "Any complaintsregarding care or services may be made to the Department of Public Healthand Addiction Services, Hospital and Medical Care Division, 150 WashingtonStreet, Hartford, Connecticut 06106.". The bill of rights shall providethat each patient:

(1) is fully informed of these rights, as evidenced by his or her written acknowledgment, prior to or at the time of admission;

(2) is fully informed by a physician of his or her medical condition, unless medically contraindicated as documented by the physician in the medical record, and is afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research;

(3) may be physically or chemically restrained only to ensure their physical safety and only upon the written order of a physician that specifies the type of restraint and the duration and circumstances under which the restraints are to be used, except in emergencies until a specific order can be obtained;

(4) is assured confidential treatment of his or her medical records, and may approve or refuse their release to any individual outside the center, except in case of transfer to another health care institution or as required by law or third-party payment contract;

(5) is advised of the requirements of the Patient Self Determination Act of 1990, P.L. 101–508, section 4206 (a)(2) and section 4751 (a)(2) on advance directives; and

(6) is encouraged and assisted, throughout the length of stay, to exercise his or her rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to center staff, free from abuse, restraint, interference, coercion, discrimination or reprisal.

(h) **Reportable event(s)**

(1) Classification. All reportable events shall be classified as follows:

(A) Class A: an event that has caused or resulted in a patient's death or presents an immediate danger of death or serious harm;

(B) Class B: an event that indicates an outbreak of disease or foodborne outbreaks as defined in section 19a-36-A1 of the regulations of Connecticut State Agencies; a complaint of patient abuse or an event that involves an abusive act to a patient by any person; for the

purpose of this classification, abuse means a verbal, mental, sexual, or physical attack on a patient that may include the infliction of injury, unreasonable confinement, intimidation, or punishment;

(C) Class C: an event (including but not limited to loss of emergency electrical generator power, loss of heat, loss of water system) that shall result in the evacuation of one (1) or more patients within or outside of the facility and all fires regardless of whether services are disrupted; or

(D) Class D: an event that has caused or resulted in a serious injury or a significant change in a patient's condition; an event which involves medication error(s) of clinical significance; or an adverse drug reaction of clinical significance which for the purpose of this classification, means an event that adversely alters a patient's mental or physical condition.

(2) All documentation of reportable events shall be maintained at the center for not less than three (3) years.

(3) The administrator or his or her designee shall report any reportable event to the department according to the following schedule:

(A) Classes A, B and C: immediate notice by telephone to the department, to be confirmed by written report as provided herein within seventy-two (72) hours of said event; and

(B) Class D: written report to the department as provided herein within seventy-two (72) hours of said event.

(4) Each written report shall contain the following information:

(A) date of report and date of event;

(B) identification of the patient(s) affected by the event including:

(i) name;

(ii) age;

(iii) injury;

(iv) distress or discomfort;

(v) disposition;

(vi) date of admission;

(vii) current diagnosis;

(viii) physical and mental status prior to the event; and

(ix) physical and mental status after the event;

(C) location, nature and brief description of the event;

(D) name of the physician consulted, if any, time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders;

(E) names of any witnesses to the event;

(F) any other information deemed relevant by the reporting authority or the licensed administrator; and

(G) signatures of the person who prepared the report and the licensed administrator.

(5) All reportable events that have occurred in the center shall be reviewed on a monthly basis by the administrator and director of nursing services. All situations that have a potential for risk shall be identified. A determination shall be made as to what preventative measures shall be implemented by the center staff. Documentation of such determination shall be

submitted to the medical staff. This documentation shall be maintained for not less than three (3) years.

(6) An investigation shall be initiated by the center within twenty-four (24) hours of the discovery of a patient(s) with an injury of suspicious or unknown origin or receipt of an allegation of abuse. The investigation and the findings shall be documented and submitted to the center's medical staff for review. This documentation shall be maintained at the center for a period of not less than three (3) years.

(7) Numbering. Each report shall be identified on each page with a number as follows: the last two (2) digits of the year and the sequential number of the report during the calendar year.

(8) Subsequent reports. The administrator shall submit subsequent reports relevant to any reportable event as often as is necessary to inform the department of significant changes in the status of affected individuals or changes in material facts originally reported. Such reports shall be attached to a photocopy of the original reportable event report.

(i) **Medical director**

(1) The medical director shall be a physician licensed to practice medicine in Connecticut, shall serve on the facility's medical advisory board, shall be board certified in a specialty appropriate to the types of patients being served in the center as specified by the governing body and shall be a member of the medical staff of a general hospital licensed in Connecticut.

(2) The position of medical director shall not be held by the same person who holds the position of administrator.

(3) In-hospital recovery care centers shall provide medical direction through the designation of a specified physician in accordance with the hospital medical staff by-laws. A minimum of ten (10) hours a week of medical direction and supervision shall be provided.

(4) The medical director in an out-of-hospital recovery care center shall be appointed by the governing body and shall have the following powers and responsibilities:

(A) enforcing the bylaws governing medical care;

(B) approving or denying applications for membership on the center's medical staff in accordance with subsection (k) of this section;

(C) appointing all physicians by letter of appointment which delineates the physicians' privileges, duties and responsibilities and is acknowledged in writing by the appointee;

(D) in accordance with the medical staff bylaws, suspending or terminating the center privileges of a medical staff member if that member is unable or unwilling to adequately care for a patient in accordance with state statutes, regulations, and standards of practice;

(E) assuring that quality medical care is provided in accordance with quality assurance requirements as established by the center; and

(F) serving as a liaison between the medical staff and administration;

(5) The medical director or his or her designee shall have the following responsibilities:

(A) approving or disapproving a patient's admission based on the center's ability to provide adequate care for the individual in accordance with the medical staff bylaws and subsection (c) of this section by record review or patient examination prior to admission;

(B) assuring that each patient in the center has an assigned personal physician;

(C) providing or arranging for the provision of necessary medical care to the patient if

the individual's personal physician is unable or unwilling to do so;

(D) visiting the center daily to assess the adequacy of medical care provided in the center;

(E) providing a minimum of twenty (20) hours a week of medical direction and supervision on-site;

(F) receiving reports from the director of nurses on significant clinical developments; and

(G) documenting visits to the recovery care center which shall minimally include the date and time of the visit, the names of the patients reviewed and a summary of problems discussed with the staff.

(j) **Medical staff and allied health professionals. In-hospital recovery care centers.** In-hospital recovery care center medical staff and allied healthprofessional appointments shall be consistent with the medical stafforganization and bylaws.

(k) **Medical staff and allied health professionals.** Out-of-hospital recoverycare centers

(1) All members of the medical staff and allied health professionals shall:

(A) possess a full and unrestricted Connecticut license; and

(B) satisfy specific standards and criteria set in the medical bylaws of the center.

(2) All members of the medical staff shall be available by phone twenty-four (24) hours a day, be available to respond promptly in an emergency, and be able to provide an alternate physician for coverage whenever necessary.

(3) Each member of the center's medical staff shall sign a statement attesting to the fact that such member has read and understood the center's medical bylaws, policies and procedures, and applicable statutes and regulations, and that such member shall abide by such requirements to the best of his or her ability.

(*l*) **Medical advisory board members. Out-of-hospital recovery care centers**

(1) The center shall have a medical advisory board. The medical advisory board shall include no less than five (5) physicians licensed in Connecticut.

(2) The medical advisory board shall meet at least once every ninety (90) days. Minutes shall be maintained for all such meetings with copies sent to all medical staff members. The regular business of the medical advisory board meetings shall include, but not necessarily be limited to, the hearing and consideration of reports and other communications from physicians, the director of nursing services, and other health professionals on:

(A) patient care topics, including all deaths, accidents, complications and infections; and

(B) interdisciplinary care issues including, but not necessarily limited to, nursing, physical therapy, social work and pharmacy.

(3) Medical advisory board members shall attend at least fifty percent (50%) of medical advisory board meetings per year. If two (2) or more members of the medical advisory board are members of the same partnership or incorporated group practice, one (1) member of such an association may fulfill the attendance requirements for the other members of that association provided quorum requirements are met. In such case, the member in attendance shall be entitled to only one (1) vote.

(4) The medical advisory board shall adopt written bylaws governing the medical care of the center's patients. Such bylaws shall be reviewed biennially and approved by the medical director and the governing body. The bylaws shall include, but not necessarily be limited to:

(A) acceptable standards of practice for the medical staff;

(B) criteria and methodology for evaluating the quality of medical care provided in the center;

(C) criteria by which the medical director shall decide the admission or denial of admission of a patient based on the center's ability to provide care which shall specifically define the types of physical and mental disabilities and conditions for which the center intends to provide care and services and which are consistent with the criteria for admission, types of services and diagnostic procedures that shall be performed, types of medical conditions and surgical procedures for which the center shall provide aftercare services, and admission criteria as noted in subsection (c) of this section;

(D) standards for the medical director to grant or deny privileges and to discipline or suspend the privileges of members of the medical staff, including assurance of due process in the event of such actions;

(E) quorum requirements for medical advisory board meetings, provided a quorum may not be less than fifty percent (50%) of the physicians on the medical advisory board;

(F) specific definition of services, if any, that may be provided by non-physician health professionals such as physician assistants or nurse practitioners;

(G) standards to ensure that members of the medical staff make safe, appropriate and timely referrals to other health care institutions when a patient's condition has changed since admission and said patient can no longer be safely housed in this setting;

(H) standards to ensure that, in the event of the medical director's absence, inability to act, or vacancy of the medical director's office, another physician on the center's medical advisory board is temporarily appointed to serve in that capacity; and

(I) criteria for appointment to the medical advisory board.

(m) **Director of nursing services.** In-hospital recovery care centers.In-hospital recovery care centers shall provide nursing direction throughthe designation of a specified registered nurse licensed in Connecticut inaccordance with nursing standards of practice. This designated personshall serve full time in this capacity.

(n) **Director of nursing services. Out-of-hospital recovery care centers**

(1) The director of nursing services shall be a nurse licensed and registered in Connecticut with a master's degree in nursing and at least two (2) years of experience in medical, surgical or rehabilitative nursing and one (1) year of experience in nursing service administration.

(2) The director of nursing services shall be responsible for the supervision and quality of nursing care provided in the facility. The director of nursing services' responsibilities and duties shall include, but not necessarily be limited to, the following:

(A) development and maintenance of written nursing service standards of practice, to be ratified by the governing body;

(B) development of written job descriptions for nurses and nurse's aides;

(C) development and implementation of a patient acuity system upon which the staffing model shall be based, which shall include, but not necessarily be limited to, the following:

(i) categorization of patient population;

(ii) determination of direct and indirect patient activities and related functions;

(iii) classification of care givers and levels of responsibility; and

(iv) provision of staff replacement time;

(D) development of a methodology to ensure that staffing remains appropriate to the patient population being served;

(E) appointment of nurse supervisors as required to meet the needs of the population served;

(F) coordination and direction of the total planning for nursing services, including recommending to the administrator the number and levels of nurses and nurse's aides to be employed;

(G) assistance in the development of and participation in a staff orientation and training program, in cooperation with the administrator and medical director; and

(H) appointment, with the approval of the administrator, of a nurse employed at the facility to act on behalf of the director of nursing services in temporary absences.

(3) The director of nursing services shall work forty (40) hours per week.

(o) **Nurse supervisor.** A nurse supervisor shall be a nurse registered andlicensed in Connecticut. Nursing supervision shall be provided twenty-four (24) hours a day, seven (7) days a week. The responsibilitiesof the nurse supervisor shall include:

(1) supervision of nursing activities during his or her shift;

(2) notification of a patient's attending physician if there is a significant change in the condition of the patient or if the patient requires immediate medical care, or notification of the medical director if the patient's personal physician does not respond promptly; and

(3) maintenance of standards of care.

(p) **Nursing staff**

(1) The center shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the center twenty-four (24) hours a day, seven (7) days a week.

(2) There shall be at least two (2) registered nurses on duty from seven (7) a.m. to eleven (11) p.m., seven (7) days a week. From eleven (11) p.m. to seven (7) a.m. there shall be at least one (1) registered nurse on duty. At no time shall there be less than two (2) persons in attendance for patient care.

(3) Nursing staff shall ensure that each patient:

(A) receives treatments, therapies, medications and nourishments as prescribed in the patient care plan;

(B) is clean and comfortable;

(C) is protected from accident, incident, infection, or other unusual occurrence; and

(D) is provided with teaching appropriate to his or her needs.

(4) The nurse supervisor shall report significant clinical developments to the patient's personal physician.

(5) All nursing staff shall be certified in advanced cardiac life support.

(6) All nurse's aides who are employed to provide care and services to patients must be registered with the department.

(q) **Care partners**

(1) The care partner's responsibilities are limited to the following:

(i) acting as an observer in providing information about the patient (such as temperature and appetite) to the nursing staff;

(ii) participating in the patient's educational sessions; and

(iii) being a companion to the patient.

(2) Each care partner shall be provided with all necessary training, supervision and monitoring to ensure that said person performs each activity without risk to the patient or self. This training shall be provided and accordingly documented by qualified personnel.

(r) **Medical and professional services**

(1) Admission procedures. All patients are to be certified by their attending physicians as medically stable prior to admission. Documentation to this effect shall be present in the patient's medical record.

(2) The patient or his or her next of kin or legal representative shall be provided with the names of all persons providing professional health care services to the patient.

(3) A method for identification of all patients shall be established and maintained at all times.

(4) Admission documents must include one of the following:

(A) Hospital discharge. The referring physician must complete the hospital's discharge summary and a W-10 form. Both documents must accompany the patient to the center on the day of transfer.

(B) Ambulatory surgery discharge. Copies of the referral history and physical form, anesthesiology record and post-operative instruction sheet must accompany the patient to the center at the time of transfer.

(C) Direct admissions from the community. A comprehensive medical history and medical examination shall be completed for each patient within forty-eight (48) hours prior to admission and must either accompany the patient at the time of admission or must be on file in the center prior to the admission of the patient.

(5) A patient assessment shall be completed by a registered nurse upon admission to the recovery care center.

(A) Post surgical patients shall have a post-surgical assessment that includes physical condition, post-operative status, and deviations from the pre-operative assessment.

(B) Medically stable post-institutional patients shall have physical assessments which verify the discharge summary data and transfer documents from the transferring health care agency.

(C) Admissions directly from home shall have assessments completed by all disciplines to be involved in the care of the patient which shall include, but not necessarily be limited to, health history, physical, mental and social status, evaluation of problems and rehabilitation potential.

(6) A nursing assessment shall be performed upon admission and shall include, but not necessarily be limited to, the following:

(A) temperature, pulse and respiration;

(B) blood pressure;

(C) dressing and cast checks;

(D) status of parenteral fluids or other lines;

(E) respiratory and circulatory state; and

(F) cognitive status.

(7) No medication or treatments shall be given without a physician's order. If orders are given verbally, they shall be recorded by a licensed nurse on duty or professional with

statutory authority to receive verbal orders and shall be signed by the physician within twenty-four (24) hours.

(8) Attending physicians shall visit the facility daily to assess the adequacy of medical care rendered to their patients.

(9) Informed consent. It shall be the responsibility of the facility to ensure that, except in emergency situations, the responsible physician shall obtain informed consent as a prerequisite to any procedure or treatment and provide evidence of consent by a form signed by the patient.

(10) Standards of practice. Recovery care centers and their staff shall comply with established standards of practice relative to any practice or procedure performed in the center or by any professional staff member or consultant utilized by the center.

(s) **Rehabilitation services**

(1) Rehabilitation needs shall be met either through services provided directly or through arrangements with outside resources appropriately licensed or certified, upon a physician's written order.

(2) Each rehabilitative service performed shall be recorded in the patient's record and shall be signed and dated by the person providing the service.

(3) Rehabilitation services shall be available a minimum of five (5) days a week and be provided a minimum of three (3) hours a day.

(t) **Therapeutic recreation**

(1) The recovery care center shall provide therapeutic recreation services as patient needs indicate. An assessment of each patient shall be completed within seven (7) days of admission to identify individual needs or problems to be addressed through therapeutic recreation services.

(2) Services shall be provided on an individual or group level to meet patient needs and to contribute to the overall plan of care.

(u) **Personal care services.** Provision shall be made for personal careservices based on individual patient needs.

(v) **Dietary services**

(1) The center shall meet the daily nutritional needs of the patients and is responsible to:

(A) provide a diet for each patient, as ordered by the patient's personal physician, based upon current recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council, adjusted for age, sex, weight, physical activity, and therapeutic needs of the patient;

(B) adopt a diet manual, as recommended by the center's dietitian or dietary consultant and approved by the center's medical staff which shall be used to plan, order, and prepare regular and therapeutic diets;

(C) employ a food service supervisor who is a dietitian or receives regular monthly consultation from a dietitian who shall supervise the overall operation of the dietary service; and

(D) employ sufficient personnel to carry out the functions of the dietary service and to provide continuous service over a period of twelve (12) hours, which period shall include all mealtimes.

(2) The center shall ensure that the dietary service:

(A) considers the patients' cultural backgrounds, food habits and personal food preferences in the selection of menus and preparation of foods and beverages pursuant to subparagraphs (A) and (B) of subdivision (1) of this subsection;

(B) has written and dated menus, approved by a dietitian, planned at least three (3) days in advance;

(C) distributes a menu to each patient;

(D) serves at least three (3) meals, or their equivalent, daily at regular hours;

(E) provides appropriate food substitutes of similar nutritional value to patients who refuse the food served;

(F) provides special equipment, implements or utensils to assist patients while eating, if necessary; and

(G) maintains at least a three (3) day supply of staple foods at all times.

(3) Records of menus served and food purchased shall be maintained for at least thirty (30) days.

(w) **Social work. In-hospital recovery care centers**

(1) Any in-hospital recovery care center, as defined in subsection (a) (17) (A) of this section, must provide a social work services program to the patients of the unit consistent with this section.

(2) If the provision of social work services to the in-hospital recovery care center is coordinated through the hospital social work department, these provisions must be consistent with subsection (x) of this section and must be defined in policies and procedures of the respective hospital social work department and the in-hospital recovery care center.

(x) **Social work. Out of hospital recovery care centers**

(1) Personnel and staffing requirements

(A) The delivery of social work services shall be provided by a social worker who is qualified under subsection (a) (16) of this section.

(B) If the delivery of social work services is provided by a baccalaureate level social worker, the center shall contract for regular consultation by a social work consultant who is qualified under subsection (a) (15) of this section, on no less than a monthly basis, to review the social work service program.

(C) When consultation is required, the consultant shall prepare a written report to the administrator of each visit describing hours visited, policy and procedure review, medical record review, inservice education and other significant activities.

(D) The center shall provide or contract for sufficient hours of social work service to meet the medically related psychosocial needs of all patients but not less than a ratio of one (1) hour per week per licensed bed.

(2) Social work service provision

(A) Written policies and procedures shall be developed by a social worker who is qualified under subsection (a) (16) of this section or a social work consultant who is qualified under subsection (a) (15) of this section and ratified by the governing body, and shall include, but not necessarily be limited to:

(i) identifying the responsibilities and duties of personnel who will be providing social work services to the patients;

(ii) conducting a social work intake assessment for all patients within seventy-two (72) hours of admission;

(iii) referring a patient or his or her next of kin or legal representative to appropriate agencies for financial assistance, support services, counseling services, legal services, and residential services as needed if such referrals have not already been made;

(iv) serving as liaison between patients, families, facility staff, hospital, institution or community agency staff and caregivers and significant others as necessary; and

(v) ensuring the confidentiality of all patients' social, emotional and medical information.

(B) Social work services shall be provided to assist each patient or his or her next of kin or legal representative in adjusting to the social and emotional aspects of the patient's illness, treatment(s) and stay in the center. Services provided to the patient shall be documented in the patient's medical record.

(C) The social worker or social work consultant shall be responsible for reviewing the discharge or transfer of each patient.

(D) All staff of the center shall receive inservice training by a social worker or social work consultant at least twice a year in an area specific to the needs of the center's patient population.

(y) **Pharmaceutical services. In-hospital recovery care center.** Pharmaceutical services for in-hospital recovery care centers shall ensurethe availability of pharmaceutical services to meet the needs of the patients. All such pharmaceutical services shall be provided in accordance with applicable federal and state laws and regulations andhospital policies and procedures.

(z) **Pharmaceutical services. Out-of-hospital recovery care center**

(1) Services

(A) The center shall ensure the availability of pharmaceutical services to meet the needs of the patients. All such pharmaceutical services shall be provided in accordance with all applicable federal and state laws and regulations. Drug distribution and dispensing functions shall be conducted through a pharmacy licensed in Connecticut.

(B) The pharmaceutical services obtained by the center shall be provided under the supervision of a pharmacist.

(i) The center shall have a written agreement with a pharmacist to serve as a consultant on pharmaceutical services.

(ii) The consultant pharmacist shall visit the center at least every three (3) months to review the pharmaceutical services provided, make recommendations for improvements and monitor the service to ensure the ongoing provision of accurate, efficient and appropriate services.

(iii) Signed and dated reports of the pharmacist's quarterly reviews, findings and recommendations shall be forwarded to the center's administrator, medical director, and director of nursing services and be kept on file in the center for no less than three (3) years.

(iv) The center shall ensure that a pharmacist is responsible for the following functions: compounding, packaging, labeling, dispensing and distributing all drugs to be administered to patients; monitoring patient drug therapy for potential drug interactions and incompatibilities; notifying attending physicians of any potential drug interactions and incompatibilities which are identified during this review; and inspecting all areas within

the center where drugs (including emergency supplies) are stored at least quarterly, to ensure that all drugs are properly labeled, stored and controlled.

(2) Proper space and equipment shall be provided within the center for the storing, safeguarding, preparation, dispensing and administration of drugs.

(A) Any medication storage or administration area shall serve clean functions only and shall be well illuminated and ventilated.

(B) All medication cabinets shall be closed and locked when not in use unless they are stationary cabinets located in a locked room that serves exclusively for storage of drugs and supplies and equipment used in the administration of drugs.

(C) Controlled substances shall be stored and handled in accordance with provisions set forth in Chapter 420b of the Connecticut General Statutes and regulations thereunder.

(3) The center shall develop, implement and enforce written policies and procedures for control and accountability, distribution, and assurance of quality of all drugs and biologicals, which shall include, but not necessarily be limited to, the following:

(A) Records shall be maintained for all transactions involved in the provision of pharmaceutical services as required by law and necessary to maintain control of, and accountability for, all drugs and pharmaceutical supplies.

(B) Drugs shall be distributed in the center in accordance with the following requirements:

(i) All medications shall be dispensed to patients on an individual basis except for predetermined floor stock medication.

(ii) Floor stock shall be limited to emergency drugs, contingency supplies of legend drugs for initiating therapy when the pharmacy is closed, and routinely used non-legend drugs.

(iii) Emergency drugs shall be readily available to staff in a designated location.

(C) Drugs and biologicals shall be stored under proper conditions of security, segregation and environmental control at all storage locations.

(i) Drugs shall be accessible only to legally authorized persons and shall be kept in locked storage at any time a legally authorized person is not in immediate attendance.

(ii) All drugs requiring refrigeration shall be stored separately in a locked refrigerator or in a locked room that is used exclusively for medication and medication adjuncts.

(iii) The inside temperature of a refrigerator in which drugs are stored shall be maintained within a 36˚ to 46˚ Fahrenheit range.

(D) All drugs shall be kept in containers that have been labeled by a pharmacist or in their original containers labeled by their manufacturer and shall not be transferred from the containers in which they were obtained except for preparation of a dose for administration.

(E) Drugs and biologicals shall be properly labeled as follows:

(i) Floor stock containers shall be labeled with at least the following information: name and strength of drug; manufacturer's lot number or internal control number; and expiration date.

(ii) The label for containers of medication obtained from a community pharmacy shall include at least the following information: name, address and telephone number of the dispensing pharmacy; name of the patient; name of the prescribing practitioner; name, strength and quantity of drug dispensed; date of dispensing the medication; route of

administration; and expiration date. Specific directions for use must be included in the labeling of prescriptions containing controlled substances.

(iii) The label for containers of medication dispensed to patients for inpatient self-care use or at discharge from the center shall include at least the following information: name, address and telephone number of the dispensing pharmacy; name of the patient; name of the prescribing practitioner; specific directions for use; name, strength, quantity of the drug dispensed; route of administration; and date of dispensing.

(iv) In cases where a multiple dose package is too small to accommodate a standard prescription label, the standard label may be placed on an outer container into which the multiple dose package is placed. A reference label containing the name of the patient, prescription serial number and the name and strength of the drug shall be attached to the actual multiple dose package. Injectables intended for single dose that are ordered in a multiple quantity may be banded together for dispensing and one label placed on the outside of the banded package.

(F) Drugs on the premises of the center that are outdated, visibly deteriorated, unlabeled, inadequately labeled, discontinued, or obsolete shall be disposed of in accordance with the following requirements:

(i) Controlled substances shall be disposed of in accordance with Section 21a-262-3 of the Regulations of Connecticut State Agencies.

(ii) Non-controlled substances shall be destroyed on the premises by a licensed nurse or pharmacist in the presence of another staff person, in a safe manner so as to render the drugs non-recoverable. The center shall maintain a record of any such destructions including as a minimum the following information: date, strength, form and quantity of drugs destroyed; and the signatures of the persons destroying the drugs and witnessing the destruction.

(iii) Records for the destruction of drugs shall be kept on file for three (3) years.

(G) Current pharmaceutical reference material shall be kept on the premises in order to provide the professional staff with complete information concerning drugs.

(4) The center shall develop and follow written policies and procedures for the safe prescribing and administration of drugs.

(A) Medication orders shall be explicit as to drug, dose, route, frequency, and if pro re nata (p.r.n.), reason for use.

(i) Controlled substances not specifically limited as to time or number of doses shall be stopped within three (3) days.

(ii) A staff member shall notify the practitioner of the impending stop order prior to the time the drug would be automatically stopped.

(B) Patients shall be permitted to self-administer medications on a specific written order from the physician. Self-administered medications shall be monitored and controlled in accordance with procedures established in the center. A medication administration record must be utilized to document self-administered medications.

(C) Medication errors and apparent adverse drug reactions shall be recorded in the patient's medical record, reported to the attending physician, director of nursing services, and consultant pharmacist, as appropriate, and described in a full incident report in accordance with subsection (h) of this section.

(5) A pharmacy and therapeutics committee shall oversee the pharmaceutical services

provided, make recommendations for improvement thereto, and monitor the service to ensure its accuracy and adequacy.

(A) The committee shall be comprised of at least one (1) pharmacist, the center's director of nursing services, the center's administrator, and a physician.

(B) The committee shall meet at least quarterly, and document its activities, findings and recommendations.

(C) Specific functions of the committee shall, include but not necessarily be limited to the following:

(i) developing procedures for the distribution and control of drugs and biologicals in the center in accordance with this subsection;

(ii) reviewing adverse drug reactions that occur in the center and reporting clinically significant incidents to the federal Food and Drug Administration; and

(iii) reviewing medication errors that occur in the center and recommending appropriate action to minimize the recurrence of such incidents.

(aa) **Intravenous therapy program. In-hospital recovery care centers.** Intravenous therapy in in-hospital recovery care centers shall be provided in a manner consistent with hospital policy and procedures.

(bb) **Intravenous therapy program. Out-of-hospital recovery care centers**

(1) Intravenous therapy program prohibited, exceptions. The administration of IV therapy is prohibited except when administered directly by a licensed physician or as provided in subdivision (2) of this subsection.

(2) Approved IV therapy program. IV therapy may be administered in the center provided the center applies for permission from the commissioner, and the commissioner or the commissioner's designee approves the center's application.

(3) The center shall submit to the department a written protocol that shall demonstrate that the program shall be developed and implemented in a manner that ensures safe care for all patients receiving IV therapy and shall include but not necessarily be limited to the following:

(A) the name and credentials of the IV therapy trainer in the event the facility elects to conduct an in-house IV therapy training program;

(B) a description of the objectives, goals and scope of the IV therapy program;

(C) names, titles, duties and responsibilities of persons responsible for the direction, supervision and control of the program and alternates to serve in their absences; and

(D) written policies and procedures concerning the establishment of the standards for education, training, ongoing supervision, in-service education and evaluation of all personnel in the program including the IV therapy nurses, licensed nursing personnel and supportive nursing personnel; the origin, form, content, duration and documentation of physician orders for the IV therapy; the safe administration, monitoring, documentation and termination of IV therapy; the safe preparation, labeling and handling of IV admixtures; the procurement, maintenance, and storage of specific types of equipment and solutions that will be used in the program; IV therapy related complications, early recognition of the signs and symptoms of sepsis and acute untoward reaction, and appropriate intervention in a timely manner; surveillance, prevention and review of infections associated with IV therapy; and the ongoing review of the effectiveness and safety of the program to include

problem identification, corrective action and documentation of same.

(4) An IV therapy nurse operating an approved IV therapy program pursuant to a physician's order may:

(A) initiate a venipuncture in a peripheral vein and deliver an IV fluid or IV admixture into the blood stream;

(B) deliver an IV fluid or IV admixture into a central vein; and

(C) administer blood and blood components.

(5) An IV therapy nurse may insert and remove Peripheral Intravenous Catheter (PICC) lines upon the order of a physician. There shall be radiological confirmation of catheter position when the tip placement is positioned beyond the axillary vein prior to use of the PICC for any reason.

(6) Only a physician licensed in Connecticut may initiate or terminate a central vein access.

(7) Only an IV therapy nurse or physician may use a central vein access for blood drawing purposes.

(8) A person trained in phlebotomy procedures may use a peripheral line access for blood drawing purposes.

(9) Blood and blood components may be administered provided the following conditions are met:

(A) A physician shall be in the center during the period of time in which the blood and blood components are being administered.

(B) Vital signs (blood pressure, temperature, pulse and respirations) shall be monitored and documented, prior to initiating the infusion of a blood and blood component IV, every fifteen (15) minutes during the first hour of administration and every hour until the transfusion is completed.

(C) The administration of blood or blood components shall be completed in accordance with standards of practice.

(10) An IV therapy nurse may deliver an IV fluid or IV admixture or blood and blood components into the blood stream via existing lines, monitor, care for the venipuncture site, terminate the procedure, and record pertinent events and observations.

(11) A log shall be maintained of each IV therapy procedure and blood and blood component administration initiated and shall be made available to the department upon the request of the commissioner. The log shall contain as a minimum the following information: date and time of initiating the procedure, name of patient, name of prescriber, description of the therapy, date and time of terminating the therapy, outcome of the therapy, and complications encountered, if any.

(12) Negative reactions to blood and blood components shall be reported to the department within twenty-four (24) hours and as required by the blood bank of the cooperating hospital.

(13) There shall be no changes in the protocol developed pursuant to subdivision (3) of this subsection or modifications in the scope of the IV therapy program as defined in subsection (a) (11) of this section without the written approval of the commissioner.

(14) Approval to participate in the program may be revoked at any time for failure to comply with this subsection.

(cc) **Diagnostic services**

(1) All diagnostic services shall be provided only on the order of a Connecticut licensed physician, dentist, podiatrist, physician assistant or advanced practice registered nurse.

(2) Out-of hospital recovery care centers shall arrange for diagnostic services through written agreements with facilities appropriately licensed and certified to provide such services.

(dd) **Out-of-hospital recovery care center transfer agreements**

(1) A licensed recovery care center shall have a written transfer agreement with one (1) or more hospitals. This agreement shall ensure that:

(A) patients shall be transferred from the center to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by a physician; and

(B) medical and other information needed for care and treatment of a patient is transferred with the patient.

(2) A licensed recovery care center shall have a written agreement with one (1) or more ambulance service(s) staffed with emergency medical technicians qualified under subsection 19a-179-16 (b) of the regulations of Connecticut State Agencies. This agreement shall ensure an immediate response by the ambulance service for emergency medical services or transportation to a hospital.

(ee) **Medical records**

(1) The center shall maintain a complete medical record for each patient. All parts of the record pertinent to the daily care and treatment of the patient shall be maintained on the nursing unit in which the patient is located.

(2) The complete medical record that is initiated at the time of admission shall include, but not necessarily be limited to:

(A) patient identification data, including name, date of admission, most recent address prior to admission, date of birth, sex, marital status and religion;

(B) referral source;

(C) insurance numbers;

(D) next of kin or legal representative and address and telephone number;

(E) name of patient's attending physician;

(F) complete medical diagnosis;

(G) all initial and subsequent orders by the physician;

(H) a patient assessment completed upon admission;

(I) the initial patient care plan which is based on the patient assessment, developed within three (3) hours of the patient's admission, including input by all disciplines involved in the care of the patient within twenty-four (24) hours of admission, containing the identification of patient problems and needs, treatments, approaches and measurable goals and updated as necessary but no less frequently than every seven (7) days;

(J) a record of all visits by the physician including physician progress notes;

(K) nurses notes including condition on admission, current condition, ongoing monitoring, changes in patient condition, treatments and responses to such treatments;

(L) a record of medications administered including the name and strength of drug, date, route and time of administration, dosage administered and with respect to p.r.n. medications,

reasons for administration, patient response and result(s) observed;

(M) documentation of all care and ancillary services rendered;

(N) summaries of conferences and records of consultations if applicable; and

(O) record of any physician visits, treatment, medication or service refused by the patient and the patient's understanding of the potential effects of the refusal which shall be documented in the medical record by the physician, physician assistant or registered nurse and signed by the patient whenever possible.

(3) All entries in the patient's medical record shall be typewritten or written in black ink and legible. All entries shall be verified according to accepted professional standards (i.e., legal signature: first name or initial, last name and discipline).

(4) Medical records shall be safeguarded against loss, destruction or unauthorized use.

(5) All medical records, originals or copies, shall be preserved for at least ten (10) years following the death or discharge of the patient. In-hospital recovery care centers shall maintain records according to section 19-13-D3(d) of the regulations of Connecticut State Agencies.

(ff) **Discharge planning**

(1) Patient education shall begin on the day of admission and shall focus on the individual's immediate post discharge needs.

(2) Every patient shall have a written discharge plan that shall be given to the patient or his or her next of kin or legal representative prior to discharge.

(3) The discharge plan shall include but not necessarily be limited to identification of the patient's needs for continued skilled care or support services and the specific resources to be utilized to meet these needs.

(4) The discharge plan shall be completed on a timely basis so that appropriate arrangements for post discharge care management are made before discharge.

(5) The discharge plan shall be developed in collaboration with the patient, or his or her next of kin or legal representative, and the social worker and other care providers.

(6) The discharge plan shall be approved by the physician of record.

(7) The written discharge plan shall be signed by the patient or his or her next of kin or legal representative indicating their understanding of the discharge plan of care.

(8) The documentation of the written discharge plan shall be retained as a permanent part of the patient's medical record.

(9) Information necessary to ensure the continuity of care shall be sent to participating providers in a timely manner to ensure continuity of care.

(gg) **Infection control. In-hospital recovery care centers.** Infection control practices for in-hospital recovery care centers shall be consistent with hospital policy, procedure and standards.

(hh) **Infection control. Out-of-hospital recovery care centers**

(1) The center shall develop an infection prevention, surveillance and control program which shall have as its purpose the protection of patients and personnel from nosocomial infections and community-associated infections.

(2) The structure and function of this program shall be approved by, and become a part of the bylaws or rules and regulations of, the medical staff of the center. The authority for this program shall be delegated to an infection control committee which shall report on its

activities with recommendations on at least a quarterly basis to the medical advisory board for their consideration and action.

(3) The membership of the infection control committee shall include representatives from the center's administration, medical staff, nursing staff, pharmacy, dietary, maintenance and housekeeping. The committee shall meet at least quarterly. Minutes of all meetings shall be maintained for ten (10) years.

(4) The infection control committee shall:

(A) adopt working definitions of nosocomial infections;

(B) develop standards for surveillance of incidence of nosocomial infections and conditions predisposing to infection;

(C) develop a mechanism for monitoring and reporting infections in patients and environmental conditions with infection potential; and

(D) develop control measures including an isolation policy, aseptic techniques, and a personal health program.

(5) The chairman of the infection control committee shall be a Connecticut licensed physician and shall be a member of the active medical staff of a general hospital licensed in Connecticut.

(6) The services of a physician, board certified in infectious diseases, shall be available to the infection control committee and chairman, as needed.

(7) There shall be a registered nurse employed by the center who shall conduct the infection control program as directed by the infection control committee. This individual shall be directly responsible to, and be a member of, the infection control committee. This individual shall make a monthly report to the medical director and a quarterly report to the medical advisory board.

(8) The infection control committee shall meet at least quarterly and shall, at a minimum:

(A) review information obtained from day-to-day surveillance activities of the program;

(B) review and revise existing standards; and

(C) report to the active organized medical staff.

(9) There shall be quarterly in-service education programs regarding infection prevention, surveillance and control for appropriate personnel. Documentation of these programs shall be available to the department for review.

(10) The minutes of the committee meetings shall document the review and evaluation of the surveillance data and the development and revision of measures for control of infection. These records shall be available to the department for review.

(11) The center shall comply with the requirements for the handling and disposing of biomedical wastes in accordance with applicable state and federal laws and regulations.

(ii) **Quality assurance. In-hospital recovery care centers.** In-hospital recovery care center quality assurance programs shall be consistent with the hospital program, procedures and standards to include all quality assurance components identified under subsection (jj) of this section.

(jj) **Quality assurance. Out-of-hospital recovery care centers.** The center shall have a quality assurance program to monitor and evaluate the quality and appropriateness of patient care, measure patient outcomes and pursue ways to improve patient care and resolve problems.

(1) The quality assurance program shall be implemented by a quality assurance committee comprised of the administrator, medical director, director of nursing services, at least one (1) physician from a participating surgical specialty and one (1) from medicine, two (2) staff registered nurses, one (1) of whom shall be the infection control nurse, and the social worker.

(2) The quality assurance committee shall adopt written procedures for fulfilling their responsibilities. These procedures are subject to approval by the governing body and the department.

(3) The quality assurance committee shall:

(A) review the appropriateness of patient admissions to the center;

(B) review appropriateness of the professional services provided in the center;

(C) identify opportunities for improving patient care and services;

(D) review pharmaceutical services and the appropriateness of medication usage for patients in conjunction with the consultant pharmacist;

(E) review the records of all patients requiring a third day of care for continued appropriateness of setting;

(F) review within twenty-four (24) hours all patient cases where a medical emergency or death occurs and submit to the department, within seven (7) days, a written report of their findings in such cases;

(G) review for appropriateness of admission and services, all patient cases requiring unexpected transfer to an acute facility and report to the medical director within twenty-four (24) hours of the transfer;

(H) provide for quarterly review of availability of resources necessary to respond to medical emergencies;

(I) review the procedures and surveillance program for minimizing the sources and transmission of infection, including post discharge;

(J) evaluate all services provided by contract or agreement on an annual basis or more frequently as necessary;

(K) provide for medical records review to determine accuracy and completeness of information contained in the patients' medical records; and (L) review the records of all patients who are readmitted to the recovery care center or acute care facility within ten (10) days after discharge for appropriateness of services and discharge and report such findings to the department on a quarterly basis.

(4) The quality assurance committee shall meet at least quarterly and report its findings and activities to the center's governing body and medical staff.

(5) The quality assurance committee shall be responsible to ensure that appropriate follow-up results.

(6) Minutes shall be taken at each meeting, retained at the center for five (5) years and made available to the department upon its request.

(kk) **Physical environment standards**

(1) General provisions

(A) Review of drawings and specifications

(i) No new construction of or alteration to a recovery care center, new or existing, shall be undertaken until final project drawings and specifications have been approved by the

department.

(ii) Concurrent with the submission of drawings and specifications, a project narrative shall be submitted to the department which includes a description of the overall physical project. If it is to be a distinct center within an existing licensed facility, a description of the project with the proposed use of existing services to be utilized shall also be included.

(iii) Each center shall demonstrate compliance with building and fire safety codes prior to project approval by the department.

(iv) The department may require submission of site, architectural, structural, heating, ventilation, plumbing and electrical drawings of the existing structure for alteration projects.

(v) In addition to a narrative description of the physical project, the sponsor for each project shall provide a functional program narrative for the recovery care center which defines services and programs to be provided.

(B) Recovery care center occupancy shall be classified as a health care occupancy. The recovery care center shall comply with the provisions of the State Building Code as a rehabilitative health care facility. The standards established for the construction, renovation, alteration, maintenance and licensure of all facilities as adopted by the Commissioner of the Department of Public Safety, are hereby incorporated and made a part hereof and include but are not necessarily limited to:

(i) State of Connecticut Building Codes;

(ii) State of Connecticut Fire Safety Code; and

(iii) National Electrical Code.

(C) The standards established within the Public Health Code of the State of Connecticut for the construction, renovation, alteration, maintenance and licensure of all facilities, as may be amended from time to time, are hereby incorporated and made a part hereof by reference.

(2) Waiver(s)

(A) The commissioner or his or her designee, in accordance with the general purposes and intent of this section, may waive provisions of this subsection if the commissioner determines that such waiver would not endanger the life, safety or health of any patient. The commissioner shall have the power to impose conditions which assure the health, safety and welfare of patients upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized.

(B) Any facility requesting a waiver shall apply in writing to the department. Such application shall include:

(i) the specific regulations for which the waiver is requested;

(ii) reasons for requesting the waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;

(iii) the specific relief requested; and

(iv) any documentation which supports the application for waiver.

(C) In consideration of any application for waiver, the commissioner or his or her designee may consider the level of care provided, the maximum patient capacity, the impact of a waiver on care provided, and alternative policies or procedures proposed.

(D) The department reserves the right to request additional information before processing an application for waiver.

(E) Any hearing held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and sections 19a-4-1 through 19a-4-31 of the regulations of Connecticut State Agencies, as applicable.

(3) General conditions

(A) Applicability. This subdivision covers freestanding facilities or a distinct part of a health care facility and represents minimum requirements for new construction or alterations.

(B) Ancillary services. When the recovery care center is part of, or contractually linked with another facility, services such as dietary, storage, pharmacy, and laundry may be shared insofar as practical. In some cases, ancillary service requirements may be met by the principal facility. In other cases, programmatic concerns and requirements may dictate separate services.

(C) Basic requirements

(i) The recovery care center shall provide sufficient space to accommodate all administrative, business, clinical, medical records, professional staff and support functions.

(ii) The sponsor shall demonstrate that the project drawings will meet the functional program submitted to the department.

(iii) A separate entry to the recovery care center shall be provided.

(iv) Services of the recovery care center shall be provided in a distinct location of the facility.

(v) Site locations shall be accessible to emergency service vehicles.

(vi) Paved walkways shall be provided for each exit from the building leading to a driveway or street.

(vii) Handicapped and staff visitor parking shall be provided in proximity to the recovery care center entrance.

(D) Administration and public areas. The following shall be provided:

(i) an entrance at grade level, sheltered from inclement weather, and accessible to the handicapped;

(ii) a lobby to include a reception and information counter or desk, waiting space(s), access to public toilet facilities, public telephones, and drinking fountain(s);

(iii) spaces for private interviews relating to social service, credit or admissions;

(iv) general or individual office(s) for business transactions, medical and financial records and administrative and professional staffs;

(v) multipurpose room(s) for conferences, meetings and education purposes;

(vi) storage for office equipment and supplies; and

(vii) adequate space for reviewing, dictating, sorting, recording, and storing of medical records.

(E) Nursing unit. Each nursing unit shall comply with the following:

(i) The size of the nursing unit shall not exceed forty-five (45) beds.

(ii) The maximum travel distance from the nurses' station to a patient bedroom door shall be one hundred and fifty (150) feet.

(F) Patient rooms

(i) Maximum room occupancy shall be two (2) patients.

(ii) Minimum room areas (exclusive of toilets, closets, wardrobes, alcoves or vestibules)

shall be one hundred and twenty (120) square feet for a single bedroom and one hundred (100) square feet per bed in multiple-bed rooms.

(iii) In multiple-bed rooms, clearance shall allow for the movement of beds and equipment.

(iv) The dimensions and arrangement of rooms shall be such that there is a minimum of four (4) feet clearance between the sides and foot of the bed and any wall, other fixed obstruction, or furniture and six (6) feet between beds in multiple-bed rooms.

(v) Handwashing facilities shall be provided within each patient room.

(vi) Each patient shall have access to a toilet room without having to enter the general corridor area.

(vii) The toilet room shall contain a water closet and a handwashing fixture and the door should swing outward or be double acting.

(viii) A toilet room may not serve more than two (2) patients.

(ix) All associated patient bathrooms and toilet rooms shall be accessible to the physically disabled.

(x) In recovery care centers which specialize in rehabilitative services, a minimum of fifty percent (50%) of patient rooms shall be equipped with a private bathing unit.

(xi) Cubicle curtains shall be provided in each bedroom.

(xii) The design for privacy shall not restrict patient access to the entrance, lavatory or toilet.

(xiii) The following equipment shall be provided for each patient in each bedroom: one (1) closet or wardrobe with adjustable clothes rod and a shelf of sufficient size and design to hang clothing; one (1) dresser with three (3) separate storage areas for patient clothing; one (1) adjustable hospital bed with gatch spring, and side rails; one (1) moisture proof mattress; one (1) enclosed bedside table; one (1) overbed table; one (1) chair; one (1) full length mirror; and one (1) piped oxygen and vacuum outlet.

(G) Isolation Room(s)

(i) At least one (1) isolation room, designed to minimize infection hazards to or from the patient, shall be provided for each nursing unit.

(ii) Each isolation room shall contain only one (1) bed and shall be located within individual nursing units. These rooms may be used for regular care when not required for isolation cases.

(iii) A handwash sink shall be provided within the room.

(iv) Room entry shall be through a work area that provides for facilities that are separate from patient areas for handwashing, gowning, and storage of clean and soiled materials. The work area entry shall be a separate enclosed anteroom. A viewing panel shall be provided for observation of each patient by staff from the anteroom.

(v) One (1) separate anteroom may serve several isolation rooms.

(vi) Toilet, shower or bathing unit, and handwashing facilities are required for each isolation room. These shall be arranged to permit access from the bed area without the need to enter or pass through the work area of the vestibule or anteroom.

(vi) Piped oxygen and vacuum shall be provided.

(H) Central Bathing Facilities. At least one (1) central bathing unit shall be provided in each nursing unit.

(i) One (1) shower or bathing unit shall be provided for each ten (10) beds not equipped with a private bathing unit.

(ii) Each bathtub or shower shall be in an individual room or enclosure that provides privacy for bathing, drying, and dressing.

(iii) Special bathing facilities, including space for attendant, shall be provided for patients on stretchers, carts, and wheelchairs.

(iv) At least one (1) bathing unit shall have four (4) feet clearance of three (3) sides.

(v) Bathing and shower rooms shall be of sufficient size to accommodate a patient and attendant and shall not have curbs.

(vi) Controls shall be located outside shower stalls.

(vii) Patient toilet rooms shall be conveniently located to each central bathing facility.

(viii) A handwash sink and storage cabinet(s) shall be provided within the central bathing facility.

(ix) Patient toilet room(s) of handicapped design shall be conveniently located to multi-purpose rooms and may also be designated for public use.

(x) At least one (1) handicapped accessible shower shall be located within each central bathing unit.

(I) Nursing Station

(i) The area shall have space for counters and storage, and shall have convenient access to handwashing facilities. The station shall permit visual observation of traffic into the unit. A minimum of one hundred and fifty (150) square feet for a thirty (30) bed nursing unit or two hundred (200) square feet for a forty-five (45) bed nursing unit shall be provided.

(ii) A dictation area shall be adjacent to, but separate from the nurse's station.

(iii) A separate charting room of one hundred (100) square feet shall be located adjacent to the nursing station.

(iv) A storage area for active charts and office supplies shall be provided.

(v) Nurse or supervisor office space shall be provided.

(vi) A staff toilet room shall be conveniently located to each nursing station.

(vii) Staff lounge and locker facilities shall be provided. These facilities may be on another floor.

(viii) Lockable closets, drawers, or compartments shall be provided for safekeeping of staff personal effects.

(ix) Emergency equipment storage space that is easily accessible to staff, such as a crash cart, shall be available.

(x) Essential equipment. The following medical equipment shall be provided at each nursing station: one (1) gurney stretcher and one (1) wheelchair; one (1) suction machine; one (1) oxygen cylinder with transport carrier; manual breathing bag, mask and airways; cardiac defibrillator; cardiac monitoring equipment; tracheotomy set; emergency medical equipment and related supplies specified by the medical staff; and cardiac board. The following support equipment shall be provided at each nursing station: one (1) mobile chair scale; one (1) water cooler; public telephone; and one (1) ice machine.

(J) Examination and treatment room. One (1) examination and treatment room shall be provided for each nursing unit. Such rooms shall have a minimum floor area of one hundred and twenty (120) square feet. The room shall contain a handwashing fixture, storage

facilities, a desk, counter, or shelf space for writing and one (1) oxygen and vacuum outlet.

(K) Clean utility room. There shall be a clean utility room of a least one hundred (100) square feet. It shall minimally contain a counter, enclosed locked storage cabinets and handwashing facilities.

(L) Soiled utility room. There shall be a soiled utility room of at least one hundred and ten (110) square feet. It shall minimally contain a handwashing facility, a bedpan flushing and washing device, a flushrim sink, locked cabinet storage and a work counter. The room may be utilized for the temporary storage of bio-medical waste.

(M) Medication preparation room. There shall be a medication preparation room of at least eighty (80) square feet. The room shall be visually controlled from the nurse's station. It shall contain a work counter, sink, refrigerator, locked storage for controlled drugs and space for medication carts.

(N) Soiled linen holding room. A separate room of at least sixty (60) square feet shall be provided.

(O) Clean linen storage. A separate closet shall be designated for the storage of linen, blankets, pillows, towels and personal belongings.

(P) Bulk equipment storage room. There shall be a bulk equipment storage room of at least one hundred and fifty (150) square feet for thirty (30) beds or two hundred (200) square feet for forty-five (45) beds.

(Q) Wheelchair storage. Storage space for wheelchairs shall be available.

(R) Nourishment station. This room shall contain a work counter, refrigerator, storage cabinets and a sink for serving nourishments between meals. Ice for resident consumption shall be provided by ice maker units.

(S) Medical supply room. There shall be a medical supply room of at least one hundred and fifty (150) square feet.

(T) Oxygen storage. Storage space of twenty-five (25) square feet for oxygen shall be provided.

(U) Patient support areas. Each recovery care center shall provide the following:

(i) a dining area with a minimum of twenty (20) square feet per patient in a distinct, centrally located area;

(ii) a lounge with a minimum area of two hundred and fifty (250) square feet for each thirty (30) beds or fraction thereof, with at least one (1) lounge on each nursing unit; and

(iii) storage space for supplies and resident personal needs.

(V) Rehabilitative therapy areas. Recovery care centers which specialize in rehabilitative services shall provide areas and equipment necessary for the effective function of the program. Each rehabilitative therapy area shall include the following:

(i) office and clerical space;

(ii) reception and control station(s) with visual control of waiting and activities areas which may be combined with office and clerical space;

(iii) patient waiting area(s) with provisions for wheelchairs;

(iv) space for storing wheelchairs and stretchers out of traffic; and

(v) a janitor's closet with a service sink.

(W) Physical therapy. If physical therapy is a service provided, the following minimum facilities shall be included:

(i) individual treatment area(s) with cubicle curtains for visual privacy;

(ii) handwashing facilities for staff conveniently located at each treatment space (one (1) handwashing facility may serve several treatment stations);

(iii) exercise area and related equipment;

(iv) clean linen and towel storage;

(v) separate storage for soiled linens, towels and supplies;

(vi) patient dressing areas and lockers;

(vii) a shower for patient use;

(viii) provisions for thermotherapy, diothermy, and ultrasonics when required by the functional narrative program;

(ix) toilet facilities located within the room that are accessible to the handicapped, which may also be used for toilet training; and

(x) a water cooler.

(X) Occupational therapy. If this service is provided, the following shall be included at a minimum:

(i) work areas and counters suitable for wheelchair access;

(ii) handwashing facilities;

(iii) storage for supplies and equipment; and

(iv) therapeutic equipment for activities of daily living.

(Y) Hydro therapy. If this service is provided, the following shall be included at a minimum:

(i) patient dressing areas and lockers;

(ii) showers for patient use;

(iv) limb and body tanks required to meet recovery care center narrative program requirements;

(v) individual treatment areas with cubicle curtains for visual privacy;

(vi) handwashing facilities; and

(vii) handicapped toilet facilities which may be shared if appropriate other facilities are in proximity.

(Z) Speech and hearing therapy. If this service is provided the following elements shall be included at a minimum:

(i) office space for evaluation and treatment; and

(ii) space for equipment and storage.

(AA) Respiratory therapy. If respiratory service is provided, the following elements shall be included at a minimum:

(i) office and clerical space with provision for filing and retrieval of patient records;

(ii) room(s) for patient education and demonstration;

(iii) storage space for equipment and supplies;

(iv) physical separation of the space for receiving and cleaning soiled materials from the space for storing of clean equipment and supplies; and

(v) handwashing facilities.

(BB) Laboratory services. If laboratory procedures are performed on-site, provisions shall be made for space and equipment and Federal Clinical Laboratory Improvement Act (CLIA) standards shall be met.

(CC) Dietary Facilities

(i) The functional elements of the dietary department shall provide for services that are separate from other service areas and sized to permit working space and equipment, for receiving, storing, food preparation, tray assembly, serving of food and disposal of waste products and returnable items.

(ii) The following minimum facilities shall be provided within the dietary department: receiving, breakdown and control areas; storage spaces for bulk, refrigerated and frozen foods; stock of a minimum of three (3) days supplies; freezers, capable of maintaining temperatures down to freezing; food preparation work spaces and equipment; tray assembly area; food cart distribution system with space for storage, loading, distribution, receiving and sanitizing; a dishwashing room which shall be designed to separate dirty and clean dishes and include a breakdown area and food cart hold area; waste storage room; potwashing facilities which include a three (3) pot sink; handwashing facilities located conveniently in the area; janitorial and housekeeping services; office space for food service supervisor and dietitian; toilet and locker spaces; and ice making equipment.

(iii) The dietary service shall provide for the protection of food delivered to ensure freshness, retention of hot or cold temperature and avoidance of contamination.

(iv) Under counter conduits, piping and drains shall not interfere with cleaning of the floor below the equipment. No plumbing lines shall be exposed overhead.

(v) All cooking equipment shall be equipped with automatic shut-off devices to prevent excessive heat buildup.

(vi) Dining space shall be provided for staff.

(DD) Laundry services

(i) Each recovery care center shall have provisions for storing and processing clean and soiled linen for appropriate patient care and infection control. Processing may be done within the center, in a separate building on or off-site, or in a commercial or shared laundry. (ii) The following elements shall be included: a separate room for receiving and holding soiled linen until ready for pickup or processing, a clean linen storage room, and cart storage area.

(iii) Employee handwashing facilities shall be provided in each area where clean and soiled linen is processed or handled.

(iv) If linen is processed in a laundry on-site, the recovery care center shall provide a laundry processing room with commercial-type equipment that is arranged to permit an orderly work flow and minimize cross traffic that might mix soiled and clean operations.

(v) Linens and towels shall be provided, sufficient for four (4) times the licensed capacity of the center.

(EE) Waste storage and disposal. Waste processing services shall provide for the sanitary storage, treatment or disposal of waste and infectious materials of the center.

(FF) Housekeeping Rooms. Housekeeping rooms shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each housekeeping room shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. There shall not be less than one (1) housekeeping room for each floor or nursing unit.

(GG) Elevators

(i) Where patient beds or patient facilities and services are located on any floor other than the grade level entrance, the size and number of elevators shall be based on the following criteria: number of floors, number of beds per floor, procedures or functions performed on upper floors, and level of care provided.

(ii) In no instance shall elevators be less than the following: for one (1) to sixty (60) beds located above the main floor, one (1) hospital elevator; or for sixty-one (61) to two hundred (200) beds located above the main floor, two (2) hospital elevators.

(iii) An elevator shall be provided to service facilities located above or below the first floor such as materials handling and infectious waste.

(iv) At least one (1) elevator shall be connected to the emergency electrical equipment system.

(HH) Service and equipment areas. The following shall be provided as essential for effective service and maintenance functions:

(i) rooms for boilers, mechanical and electrical equipment;

(ii) general maintenance shop(s) for repair and maintenance;

(iii) general storage room(s); and

(iv) storage for solvents and liquids.

(II) Operational features

(i) Patient rooms shall open into a common corridor.

(ii) Doors. The minimum width of a door to patient bedrooms, central bathing units, examination and treatment rooms and to treatment and rehabilitation areas shall not be less than forty-six (46) inches. All other doors to patient and staff use areas shall not be less than three (3) feet wide. Floor hardware for patient use shall be of a design to permit ease of opening. Doors to all rooms containing bathtubs, showers, and water closets for patient use shall be equipped with privacy hardware that permits emergency access without keys. When such rooms have only one (1) entrance, the door shall open outward or be double acting.

(iii) Corridors shall be a minimum width of eight (8) feet in patient use areas. No objects shall be located so as to project into the required width of corridors.

(iv) Handrails shall be located on both sides of patient use corridors and mounted thirty-two (32) to thirty-four (34) inches above the floor. Rail ends shall be finished to minimize the potential for personal injury.

(v) Grab bars with sufficient strength and anchorage to sustain two hundred and fifty (250) pounds for five (5) minutes shall be provided at all patient toilets, showers and tubs.

(vi) Windows. Patient rooms shall be on an outside wall and have operable windows that open from the inside. Windows shall have a protective device so as to prevent accidental falls when open. Windows in patient bedrooms shall not be higher than thirty-six (36) inches above the finished floor to the sill. Windows and outer doors that may be left open shall have insect screening.

(vii) Thresholds shall be designed to comply with accessibility standards in accordance with the Americans with Disabilities Act.

(viii) Full size mirrors shall be arranged to accommodate their convenient use by patients in wheelchairs and ambulatory patients in patient bedrooms.

(ix) Patient bedrooms shall be numbered and the room capacity posted on the corridor wall on the door knob side and correlated with the fire evacuation plan.

(x) Soap and paper towel dispensers shall be provided at each staff use sink.

(xi) Ceilings shall be a minimum of eight (8) feet high in corridors, patient rooms and ancillary service areas.

(xii) Fire extinguishers shall be provided in recessed locations throughout the building as established by the local fire marshal.

(JJ) Finishes

(i) Cubicle curtains and draperies shall be non-combustible or flame-retardant as prescribed in both the large and small scale tests in National Fire Protection Association (NFPA) standard 701.

(ii) Materials provided by the facility for finishes and furnishings, including mattresses and upholstery, shall comply with NFPA 101.

(iii) Floor materials shall be readily cleanable, appropriate for the location and be maintained for patient safety. Floors in areas used for food preparation and assembly shall be water-resistant. Floor surfaces, including tile joints, shall be resistant to food acids. Floor materials shall not be adversly physically affected by germicidal cleaning solutions. Floors subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) shall have a slip-resistant surface.

(iv) Wall bases in areas subject to routine wet cleaning shall be covered, integrated with the floor, and tightly sealed.

(v) Wall finishes shall be washable, smooth and moisture-resistant.

(vi) Floor and wall openings for pipes, ducts, and conduits shall be tightly sealed to resist fire and smoke and to minimize entry of pests.

(vii) The finishes of all exposed ceilings and ceiling structures in resident rooms and staff work areas shall be readily cleanable.

(KK) Medical gas and vacuum systems

(i) The installation of nonflammable medical gas and air systems shall comply with the requirements of the most current NFPA 99 Health Care Facilities. When any piping or supply of medical gases is installed, altered, or augmented, the altered zone shall be tested and certified as required by NFPA 99.

(ii) Clinical vacuum system installations shall be in accordance with the most current NFPA 99.

(iii) All piping, except control-line tubing, shall be identified. All valves shall be tagged, and a valve schedule shall be provided to the facility owner for permanent record and reference.

(LL) Mechanical standards

(i) Boilers shall have the capacity, based upon the net ratings published by the Hydronics Institute or another acceptable national standard that is widely accepted in the boiler industry, to supply the normal heating and hot water to all systems and equipment. Their number and arrangement shall accommodate facility needs despite the breakdown or routine maintenance of any one boiler. The capacity of the remaining boiler(s) shall be sufficient to provide hot water service for clinical, dietary, and patient use.

(ii) Patient occupied areas shall be maintained in a temperature range of 72˚ and 75˚ Fahrenheit for heating purposes. Non-patient use areas may be maintained in a temperature range of 70˚ and 75˚Fahrenheit.

(iii) Air conditioning shall be provided in all patient use areas and maintained in a range of 70˚ and 76˚ Fahrenheit during the cooling season.

(iv) The ventilation systems shall be designed and balanced to provide directional flow as in Table 1.

Table 1 PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS[1]

Area designation	*Air movement relationship to adjacent area*	*Minimum air changes of outdoor air per hour*	*Minimum total air change per hour*	*All air exhausted directly to outdoors*	*Recirculated by means of room units*	*Relative humidity (%)*
PATIENT CARE						
Patient room	—	2	2	—	—	50-60
Patient area corridor	—	—	2	—	—	45-60
Toilet room	In	—	10	Yes	—	—
Isolation Room	In	1	6	Yes	No	—
Isolation Anteroom	In	—	10	Yes	No	—
DIAGNOSTIC AND TREATMENT						
Examination/Treatment	—	2	6	—	—	—
Physical therapy	In	2	6	—	—	—
Hydro therapy	In	2	6	—	—	—
Occupational therapy	In	2	6	—	—	—
Speech and Hearing	In	2	6	—	—	—
Soiled workroom	In	2	10	Yes	No	—
Clean workroom	Out	2	4	—	—	—
Medication Room	—	—	4	—	—	—

Area designation	*Air movement relationship to adjacent area*	*Minimum air changes of outdoor air per hour*	*Minimum total air change per hour*	*All air exhausted directly to outdoors*	*Recirculated by means of room units*	*Relative humidity (%)*
SUPPORT						
Laundry, general	—	2	10	Yes	No	—
Soiled linen	In	—	10	Yes	No	—
Clean linen storage	Out	—	2	Yes	No	—
Laboratory	In	—	6	Yes	No	—
SERVICE						
Food preparation center	—	2	10	Yes	Yes	—
Warewashing room	In	—	10	Yes	Yes	—
Dietary day storage	—	—	2	Yes	No	—
Janitor closet	In	—	10	Yes	No	—
Bathroom	In	—	10	Yes	No	—
Waste Storage [1]	In	—	10	Yes	No	—

1 *1 The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of recovery care centers that directly affect patient care and are determined based on health care facilities being predominantly no smoking facilities. Where smoking may be allowed, ventilation rates shall need adjustments.*

(v) Design of the ventilation system shall, insofar as possible, provide that air movement is from clean to less clean areas.

(vi) All air-supply and air-exhaust systems for interior rooms shall be mechanically operated.

(vii) Corridors shall not be used to supply air to or exhaust air from any room.

(viii) All systems which serve more than one smoke or fire zone shall be equipped with smoke detectors to shut down fans automatically. Access for maintenance of detectors shall be provided at all dampers.

(MM) Plumbing and other piping systems

(i) Plumbing fixtures. All fixtures used by medical staff, nursing staff and food handlers shall be trimmed with valves which can be operated without the use of hands. Where blade handles are used for this purpose, they shall be at least four and one-half (4 ½) inches in

length, except that handles on clinical sinks shall be not less than six (6) inches long. Single lever faucet handles shall extend six (6) inches in length.

(ii) Water supply systems. Systems shall be designed to supply water to the fixtures and equipment on the upper floor at a minimum pressure of fifteen (15) pounds per square inch during maximum demand periods. Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture. Hot water plumbing fixtures intended for patient use shall carry water at temperatures between 105˚ and 120˚ Fahrenheit.

(iii) Vacuum breakers shall be installed on hose bibbs and supply nozzles used for connection of hoses in housekeeping sinks, bedpan-flushing attachments, and outdoor hose bibbs.

(NN) Electrical standards

(i) Circuit breakers or fusible switches shall be enclosed with a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons.

(ii) Lighting and appliance panel boards shall be provided for the circuits on each floor. This requirement does not apply to emergency system circuits.

(iii) All spaces within the building, approaches thereto, and parking lots shall have electric lighting.

(iv) Patient bedrooms shall have general room lighting, overbed examination lighting, and a patient accessible reading light. General room lighting shall be switched at the room entrance and be connected to emergency power.

(v) Night lighting shall be provided in the patient bedroom and the toilet room. Night lights shall be switched at the nursing station to assure effective use.

(vi) Receptacles (convenient outlets). Each patient bed shall have a double duplex, hospital grade, grounded receptacle on each side of each bed. In addition, one (1) duplex shall be provided on each other wall in the room. If electric beds are used an additional receptacle shall be provided. At least two (2) receptacles installed at the head of each patient bed shall provide emergency power. Receptacles that provide emergency power shall be color coded red to indicate their use. Duplex grounding receptacles for general use in corridors shall be installed approximately fifty (50) feet apart and within twenty-five (25) feet of ends of corridors; and ground fault circuit interrupters shall be installed at all wet locations.

(OO) Nurse's call system

(i) In patient areas, each patient room shall be served by at least one (1) calling station for two-way voice communication. Each bed shall be provided with a call device. Two (2) call devices serving adjacent beds may be served by one (1) calling station. Calls shall activate a visible signal in the corridor at the patient's door, in the clean workroom, in the soiled workroom, and at the nursing station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two (2) or more calling stations, indicating lights shall be provided at each station. Nurse's calling systems at each calling station shall be equipped with an indicating light which remains lighted as long as the voice circuit is operating.

(ii) A nurse's emergency call system shall be provided at each inpatient toilet, bath or

shower room.

(iii) A staff emergency assistance system for staff to summon additional assistance shall be provided in examination and treatment rooms, dining, activity, and therapy areas. This system shall annunciate at the nurse station with back-up to another staffed area from which assistance can be summoned.

(PP) Emergency service

(i) The facility shall provide an emergency source of electricity, which shall have the capacity to deliver eighty percent (80%) of normal power and lighting and shall be sufficient to provide for regular nursing care and treatment and the safety of the occupants. Such source shall be reserved exclusively for emergency use.

(ii) As a minimum, each patient bed shall provide one (1) duplex electrical receptacle that is connected to the emergency power source. Task lighting and emergency power shall be provided to essential equipment in treatment areas and patient bedrooms.

(iii) Fuel shall be stored at the facility sufficient to provide seventy-two (72) hours of continuous operation.

(QQ) Telephone Systems. A telephone system shall be provided that is sufficient to meet the needs of the recovery care center's staff and patients.

(RR) Enclosed carts shall be used for transportation and handling of materials.

(SS) Prior to the licensure of the center all electrical, mechanical and fire protection systems, equipment, appliances and biomedical equipment shall be tested, balanced and operated to demonstrate that the installation and performance of these systems conform to the requirements of the plans and specifications.

(4) Operations, maintenance and housekeeping

(A) Maintenance, safety and sanitation

(i) The center shall be equipped, operated and maintained so as to sustain its safe, clean and sanitary characteristics and to minimize all health hazards. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors.

(ii) Buildings and grounds shall be maintained free of environmental pollutants and such nuisances as may adversely affect the health or welfare of patients to the extent that conditions are within the reasonable control of the recovery care center.

(iii) A written manual on the maintenance of all heating, mechanical, alarm, air conditioning and ventilation, communication, biomedical equipment and fire protection systems shall be adopted and implemented.

(iv) Maintenance logs of services performed on the equipment shall be retained for review in the recovery care center for a minimum of five (5) years.

(v) Air conditioning and ventilation systems shall be inspected and maintained in accordance with the written maintenance schedule to ensure that a properly conditioned air supply, meeting minimum filtration, humidity, and temperature requirements, is provided.

(B) Housekeeping

(i) The recovery care center shall set forth and implement written housekeeping procedures and ensure adequate numbers of housekeeping personnel to implement the program. (ii) The supervisor of housekeeping shall coordinate housekeeping activities with safety and infection control programs.

(iii) The procedures of housekeeping shall minimally provide for the use, care and cleaning of equipment; selection and use of supplies; completion of cleaning schedules; evaluation of cleaning effectiveness; and maintenance of a clean and sanitary environment.

(5) Emergency preparedness plan

(A) The recovery care center shall have a written emergency preparedness plan that includes procedures to be followed in case of medical emergencies, or in the event that all or part of the building becomes uninhabitable because of a natural or other disaster. The fire plan component shall be submitted to the local fire marshal for comment prior to its adoption.

(B) The emergency preparedness plan shall specify the following procedures:

(i) identification and notification of appropriate persons;

(ii) instructions as to locations and use of emergency equipment and alarm systems;

(iii) tasks and responsibilities assigned to all personnel;

(iv) evacuation routes;

(v) procedures and arrangements for alternative site relocation or evacuation of patients;

(vi) transfer of casualties;

(vii) transfer of records;

(viii) care of patients; and

(ix) handling of drugs and biologicals.

(C) A copy of the fire plan shall be maintained on each nursing station and in each service area. Fire evacuation plans shall be conspicuously posted in the corridor of each fire zone.

(D) All personnel shall receive training in emergency preparedness as part of their employment orientation, and annually thereafter. Staff shall be required to read and acknowledge by signature their understanding of the emergency preparedness plan as part of the orientation. The content and participants of the training orientation shall be documented in writing.

(E) Drills testing the effectiveness of the fire plan shall be conducted on each shift at least four (4) times per year. A written record of each drill, including the date, hour, description of drill, and signatures of participating staff and the person in charge shall be maintained by the facility.

(Adopted effective March 2, 1995)